HEALTH QUESTIONS

PATIENT NAME ____________________________________ HEIGHT ________ WEIGHT________ DATE __________

MEDICAL HISTORY

Please check the appropriate box if you have or have had any of the following:

CARDIAC: ❑ No significant history
❑ High Blood Pressure ❑ Chest Pain ❑ Shortness of Breath ❑ Dizziness ❑ Fainting ❑ Pacemaker ❑ Murmurs
❑ Abnormal heart rhythm -Type? ___________________________________ ❑ Valve Disorder ❑ Increased Cholesterol
❑ Other ____

PULMONARY: ❑ No significant history
❑ Spitting up Blood ❑ Asthma ❑ Shortness of Breath ❑ Recent Upper Respiratory Infection ❑ Wheezing ❑ Pneumonia
❑ Sleep Apnea - **Do you use CPAP machine?** ______ ❑ COPD/Emphysema ❑ Other________________________________

NEURO-MUSC-ORTHO: ❑ No significant history
❑ Cramps ❑ Numbness ❑ Joint Pain/Swelling ❑ Tingling ❑ Spasms ❑ Muscular Weakness ❑ Stiffness ❑ Seizures
❑ Stroke/ TIA ❑ Rheumatoid Arthritis ❑ Other:____

GI: ❑ No significant history
❑ Diarrhea ❑ Ulcer ❑ Reflux ❑ Nausea ❑ Vomiting ❑ Hemorrhoids ❑ Constipation ❑ Blood in Stool ❑ Other ____________

GU: ❑ No significant history
❑ Frequency ❑ Incontinence ❑ Discharge ❑ Urgency ❑ Discomfort ❑ Blood in Urine ❑ Stones ❑ Dribbling ❑ Recent UTI
❑ Abnormal Vaginal Bleeding ❑ Kidney Stone ❑ Other ____

SKIN: ❑ No significant history
❑ Rashes ❑ Lesions ❑ Bruising ❑ Delayed Healing ❑ Non-Healing Sores ❑ Psoriasis ❑ Mole Changes ❑ Other __________

ENDOCRINE: ❑ No significant history
❑ Diabetes/Type____________________ Frequency of Checks _________________ Usual Blood Glucose Range ______________
❑ Hyperthyroid ❑ Hypothyroid ❑ Other ____

HEMATOLOGY/IMMUNE: ❑ No significant history
❑ Steroid Use ❑ Cancer -what type? ___________________ If Breast Cancer : Lt _____ Rt _____ Bilateral _____
❑ Anemia ❑ Sickle Cell ❑ Bleeding Disorder ❑ Autoimmune Disorder ❑ HIV/AIDS ❑Hepatitis ❑ Gout ❑ Organ Transplant
❑ Other ________

MENTAL HEALTH: ❑ No significant history
❑ Depression ❑ Eating Disorder (Anorexia/Bulimia) ❑ Post-Traumatic Stress ❑ Anxiety Disorder ❑ Other __________________

PAST SURGICAL HISTORY

List previous operations and dates

____

____

____

____

ANY PROBLEMS WITH SURGERY OR ANESTHESIA?____

Bleeding/Transfusions: Have you ever had a blood transfusion? ______________________________________

MEDICATIONS

Please list any medications you are currently taking, including aspirin, birth control pills and herbal remedies

____

____

____

ALLERGIES **Have you ever had an adverse reaction to medication, drugs, or local anesthetics?** __________________________

If so, please list medication and reaction: ____

____

____

____

Have you taken aspirin-containing drugs in the past two weeks? ______________________

Have you ever had a reaction to Latex, Betadine, or surgical tape? ________ If yes, please list ______________________________________

If female, date of your last menstrual period ___________________________ **DATE OF LAST MAMMOGRAM**________________________

SOCIAL HISTORY

Do you smoke? ________ If yes, packs per day ________

Do you drink alcohol? ________ ❑ Never ❑ Occasionally ❑ Regularly Amount per day _____________________________________

Do you take recreational drugs, such as marijuana or cocaine? ________ If yes, list drugs ____

FAMILY HISTORY

(Indicate relationship: F/Father M/Mother S/Sibling C/Child G/Grandparents)

❑ Anesthesia Problems________ ❑ Diabetes________ ❑ Cancer-what type?________________ ❑ High Blood Pressure________

❑ Stroke________ ❑ Heart Problems_______ ❑ Kidney Problems________ ❑ Arthritis ________ ❑ TB________

❑ Allergies________ ❑ Seizures_______ ❑ Anemia________ ❑ Blood/Bleeding Disorders________ ❑ Depression________

❑ Mental Illness_______ ❑ Crohn's Disease________ ❑ Polyps________ ❑ Other_______________________________________

PHOTO CONSENT

"I hereby grant permission for photographs to be taken, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures."

Name: ____ Date: _____________________________________